NEUROLOGY AND SPINE CENTER

Thomas C. Morell, M.D.

Medical Records Release

Patient's Name: _____ Date of Birth: _____
Address: _____ City:_____ ST:_____ Zip:_____

Requests a release of records (TO / FROM) Doctor or Facility listed below:

_____
_____
_____

Please release all records, including but not limited to, HIV/AIDS Status, progress notes, operative notes, laboratory test results, diagnostic tests and x-rays unless otherwise stated below: _____
_____

To be sent (TO / FROM):

Neurology and Spine Center
3501 Health Center Boulevard Suite #2140
Bonita Springs, FL 34135
Phone: 239-949-9000
Fax: 239-949-9020

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

Patient Signature: _____ Date:_____

Patient Name (Printed) :_____